September 1, 2018

Secretary Marlene H. Dortch
Federal Communications Commission
Washington, DC 20554

COMMENTS
For the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of:	)	
Promoting Telehealth for Low-Income Consumers	)	W. C. Docket No. 18-213
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Dear Secretary Dortch and Members of the Commission:

The Center for the Advancement of mHealth (Center) appreciates the opportunity to comment on W.C. Docket No. 18-213-Promoting Telehealth for Low Income Consumers. The Center, a nonprofit organization and Eligible Healthcare Provider, focuses on providing high-quality health care in rural areas which are predominantly populated by low income households. The Center as an EHP also works with existing health care providers to use telehealth to connect vulnerable and underserved populations with state-licensed physicians for diagnosis and treatment in innovative ways that empower low income individuals to select their providers and adhere to care plans. Our mission is to use telehealth to reduce health disparities, help bring our service areas into compliance with goals set by Healthy People 2020 and deliver care to low income rural individuals. Because telehealth does not heavily rely on the maintenance of physical office space, the Center is able to increase access while reducing health care delivery costs.

As Chairman Pai described in his statement, referencing the 1962 episode of the Jetsons communicating with healthcare providers at the push of a button. The Center for the Advancement of mHealth performs these services NOW and can immediately deploy to low income and rural areas AND report detailed reports on utilization, outcomes and decreased costs.

From our perspective, the main point of the Notice of Inquiry is well defined with the following statement: “Analysts further estimate that widespread use of remote patient technology and virtual doctor visits could save the American health care system $305 billion annually.”

I. Overview – Improving Access and Reducing Costs

iSelectMD, formed in 2011, provides real-time healthcare access to subscribers to treat non-urgent illnesses and, when appropriate, allows providers to prescribe non-narcotic medication to resolve illnesses. iSelectMD created The Center for the Advancement of mHealth in 2016 to educate and inform wireless broadband end users of alternative healthcare delivery methods. These innovative methods improve access and reduce costs through virtual visits. At a fraction of the cost of traditional office visits, these innovative and technology driven delivery systems provide identical outcomes as physician offices, urgent care centers, emergency departments, behavioral health clinics, and addiction rehabilitation facilities at a much lower cost.

Mobile Health, also referred to as mHealth or telehealth**,** is a next generation delivery system with the capacity to offer real time diagnostic and treatment services enabled by wireless devices anywhere wireless connectivity is available. The growth in mobile health has been staggering; telehealth is expected to grow from between 18% to 30% annually in the coming years.

Telehealth offers an economic value that delivers savings at a ratio of every $1 spent equals $4 -$10 saved. This will contain the delivery costs for the provision of care in remote locations without adequate population size to support a traditional office practice. By eliminating the need for a physical office, telehealth allows rural communities to share medical providers without any upfront or ongoing operational costs. Telehealth also saves money by reducing the travel time for providers; a physician can see patients from different states in consecutive appointments while never leaving the medical office. The model provides for economies of scale. Multiple small communities can pool resources and pay for provider access on a 24/7 basis; the provider can support a predetermined number of cases which may meet or exceed the needs of the rural communities. Because this model is not reliant on insurers, the Center can provide a predictable cost of use for a three-year projection. This is not possible under models which rely on fluctuating insurance reimbursements and changes in plan coverage allowances. Because providers like the benefits of telemedicine, the Center has access to a well-established network of providers who can insure appropriate patient access starting on the first day of the pilot period. The savings can be passed down to health care consumers. Many have limited insurance coverage, often they have high deductibles or co-payments. Frequently, people understand that they need medical care but cannot afford to pay for the services. This results in patients who self-medicate, particularly in cases involving mental illness. Rural low-income communities have become the epicenter of the opioid crisis, largely because individuals with co-occurring mental health and dependency issues attempt self-care without the support of a physician.

Telehealth insures that everyone with broadband capabilities or a wireless device can have access to healthcare without waiting long periods for appointments. The average time from initiating a dial tone to a patient and provider developing a treatment plan, which may include a prescription when appropriate, is typically less than 17 minutes. This allows patients to access care quickly and conveniently. If the grant for the pilot program is awarded, the Center will deliver care in real time.

Often, individuals with limited resources do not have private transportation. In rural communities, public transportation is typically limited so they are precluded from accessing appointments for the

implementation of care plans. Many people with chronic conditions miss appointments because they are unable to reach a provider's office; telemedicine will improve care by allowing patients to keep appointments without ever leaving their homes. This will also support elderly patients and individuals with disabilities who have limited capacity to travel.

Additionally, telehealth provides ancillary benefits related to increasing public awareness and education about health disparities, wellness, and appropriate self-care. In some of the areas the Center will serve, people struggle with obesity and inadequate physical activities. These same areas report higher than expected numbers of individuals with adult onset diabetes, cardiovascular problems, and other medical conditions which can be impacted by wellness initiatives and public education. The Center will use telehealth to connect people at risk to experts in diet, physical activity, and wellness.

The access offered through telehealth empowers individuals to work with providers to diagnose potentially catastrophic illnesses when the illnesses are still treatable. The FCC USAC mHealth program can be the perfect delivery method to deploy a pilot program that facilitates the access to millions of FCC Broadband Subscribers. The Center for the Advancement of mHealth will use any funding from the pilot program to provide diagnosis and treatment for opioid dependency, mental health care, diabetes management, cardio-vascular disease, stroke treatment and prevention, and other health challenges.

II. Responses to FCC Comment Invitation

Please note that in providing comment the Center has provided feedback on areas of expertise specific to healthcare delivery and refrains from commenting on areas outside of our expertise

A. Goals of the Pilot Program

The use of broadband technology to increase access deliver obvious tangible and intangible benefits that can be best described as "Time and Money" This was the very first response to this writer from US Cellular subscriber who utilized broadband for an ear infection. Eliminated travel, wait times and expense. Many low income subscribers have to choose between a medical treatment and their phone bill. Utilizing a Connected Care Pilot program that delivered direct Provider to Subscriber access would be highly beneficial.

Improving health outcomes for a variety of healthcare conditions, including but not limited to; primary care non urgent illnesses, minor behavioral health issues, addiction and recovery, chronic illnesses and remote monitoring. In comprehensive surveys, it has been determined that the outcomes, as a result of immediate access produce the identical outcomes as in person visits at reduced costs. It has also been proven that the argument that telemedicine can be can be harmful, is not only unproven but contrary to the obvious fact that telemedicine delivers access to healthcare that did not exist in the past.

Not only can a pregnant woman's vitals be read by devices from afar but expectant women and pregnant women can eliminate unnecessary ER visits as a result of direct real time access to information and care.

Specific to geographic and demographic, telehealth delivers healthcare with no real barriers relative to time and distance. All groups that experience healthcare issues can access care, which allows an emergent situation to not be delayed by overcrowded waiting rooms in hospitals and physician clinics,

The Center strongly agrees with a direct-to-consumer model as a result of 10's of thousands of historical interactions delivered with direct-to-consumer care.

In reducing healthcare costs for patients, facilities and the Healthcare System, telehealth delivers care at a fraction of the costs with identical outcomes that reduces financial requirements with health insurance and public funding.

B. <u>Structure of the Program</u>

The Center believes that the size of the budget of $100 million is an appropriate size, and the selection of the participants should be those that can provider quantifiable reports and return on the investment. In some cases, we comment that some applicants can deliver more access and savings with more funding and should not be limited to only $5 million. We believe the application process should be thorough and focused on the direct benefit to the broadband subscriber, without limiting the access to funding to other indirect models,

We believe the eligibility criteria should be for EHP's and ETC's but not mandated to be both. The Center does believe that there should be funding access for equipment but the primary funding should be direct to the consumer.

The Center does not feel the number of projects are important, however more important will be the effectiveness of the projects selected. We do believe there are primary applicants that can deliver immediate results through access to care that are not "shovel ready" projects. Every low income and geographically challenged subscriber with a smart phone, tablet or computer can immediately receive healthcare access we once again we believe this should be the focus of the funding.

We believe the duration of the program should be 3-5 years and the applicants that prove to show the best results would continue to receive funding.

To comment on the A**pplication Process and Types of Projects to Be Supported**, the Center strongly feels the application process should include a description and geographic areas, however understands that many low income areas also fall within the borders of areas that are not entirely low income. One section of an area can often contain low, middle and high income residents.

The Center proposes and comments that the pilot program allow partnerships and must identify the broadband service providers to reach larger geographic areas of end users.

The Center proposes that there should not be restriction on eligible healthcare providers that also provide care for middle and high income utilizers. The Center has found that whether a subscriber is low or high income, access to care continues to be a challenge based on physician and provider shortages and an EHP

should not be penalized or not restricted from participating in a pilot because they do not turn away patients experiencing illnesses, addiction or treatment requests.

With eight years of experience, the Center has a wealth of knowledge and experience in telemedicine. The Center believes that the proposed pilot should be a 3-5-year program which rigorously measures and reports quantifiable outcomes and savings. The data should be collected and maintained using HIPAA compliant protocols and all results should be available to the public.

The Center believes while Eligible Telecommunications Companies (ETC's) may be an effective conduit, ETC status should not be a requirement in the grant allocation decisions. The Center, if approved for funding, would seek partnerships, potentially with multiple broadband service providers predominantly located in rural low-income areas. These partnerships would allow the Center to collect data from different parts of the United States. The Center contends that this would be helpful for the pilot program because the use of telemedicine will create a paradigm shift in the delivery of care; it is imperative to have nationwide, multi geographical results.

Furthermore, a bricks and mortar clinic or hospital should not be mandated. The ability of this project to be implemented without physical sites can be substantiated by many other consumer service related industries that connect via wireless technology from distant locations. With a direct provider to subscriber program, we believe that existing smartphone users in rural areas will most benefit from telehealth initiatives; rural areas have the highest percentage of physician shortages. In mountainous communities in Appalachia, a wireless model will provide for seamless continuity of care even during winter months when road access is compromised.

The Center believes that eligibility requirements limiting services to low income households only partially solves the nation's healthcare issues. Middle income households in the US struggle to find affordable care. Health insurance remains unaffordable for many middle-income families who may not be eligible for Medicaid assistance. Middle income families often have insurance with high deductibles and co-pays. Often, middle income families forgo visiting doctors to avoid costs; occasionally, this results in disease progression which can become life threatening and complicated to treat. Many middle-income households are in rural underserved communities. Access is problematic in remote locations regardless of income status.

The Center provided a proposed pilot program and presented funding suggestions and requirements. The proposed area of service for this pilot should include low-income areas such as, but not limited to: West Virginia (called the epicenter of the opioid epidemic by a congressional hearing), Western North Carolina, Eastern Kentucky, Iowa, Mississippi (which has only 159 doctors for every 100,000 people, the lowest rate in the nation), Alabama, and other areas determined to be rural by the United States Census Bureau.

The successful grantee should use quantifiable data to determine if the outcomes were met. The grantee should be required to report on the percentage of a pilot program population that utilizes telemedicine. This data should be securely stored in a HIPAA compliant portal or cloud. The grantee should be required to provide adequate documentation about the program operations. The grantee should be required to

provide data about how many health consumers were educated and how many accessed telehealth care services. Grantees can provide valuable data about collective numbers of illnesses and events treated by geographic area to protect patient identities.

The Center believes that the FCC has the legal authority to establish a Connected Care Pilot Program. No other agencies at the state or federal level have the expertise present at the FCC. Because the Commission has existing maps which show the correlation between low-income communities, poor health outcomes, and the lack of broadband access, the FCC is uniquely qualified. Although other federal agencies established programs for telehealth, they strategically targeted populations instead of providing broad service.

We believe the program should focus on wellness and education about health disparities, mental health and addiction treatment, primary care, and the management of chronic diseases. Based on data from Healthy People 2020 and the Robert Wood Johnson Foundation, these issues disproportionately impact low income rural areas. The Center supports the current movement towards direct-consumer healthcare and we believe that the pilot program can document quantifiable movement in the elimination of health disparities because of this trend.

One of the most significant areas of potential benefits involves cost savings. Telehealth will eliminate the costs needed to maintain brick and mortar structures and will create economies of scale. This will enable providers to pass savings to patients which will save money for insurance companies and programs like Medicaid resulting in reduced insurance premiums and savings to the taxpayers.

The Center does support the limited use of this pilot program to increase broadband deployment in underserved areas, however the primary focus should be Direct-to-Consumer. There are currently programs in place that already address this need. Broadband deployment is expensive and could deplete much of the funding without generating helpful outcomes and data about telehealth. The Center believes that the pilot program should look for transformative ideas for meaningful change in the delivery of health care.

Specific to the Number of Pilot Programs Selected, Support Amount and Disbursement the Center believes there should be a specific amount (but not limited to $5 million) based directly on the detailed criteria provided by the applicant of the desired results of the program in question. Based on the savings associated with direct-to-consumer, we do believe that $100 million would deliver the required data to ascertain the longevity and expanding the pilot to a long term program. The Center comments that the disbursement of funding should be monthly and based on the number of direct-to-consumer subscribers with access to healthcare. Below the Center has outlined their conceptual pilot program that will maximize funding and deliver detailed reporting.

C. Measuring Effectiveness of the Program

The Center comments that the metrics and reporting should be detailed and specific based on the following data:

1. Number of consumers that accessed healthcare through the participant
2. Identify illnesses treated
3. Clinical conditions of the consumers accessing care through the participant
4. Outcomes of the consumers treated verses traditional healthcare
5. Cost savings based on traditional costs associated with treating illnesses
6. Identifying the type of consumer relative to demographics

The Center comments that the EHP or recipient of the funding should be solely responsible for reporting to the commission. The Center suggests the pilot program reports should be provided on a quarterly basis.

Patient behavior can easily be reported through "potentially" required surveys, that can measure along with other reporting metrics, patient satisfaction and outcomes, as a result of the access to healthcare through the pilot program.

III. Rural Healthcare Objective

The Center's objective is to acquire funding for a small pilot program which will serve between 200,000 to 500,000 broadband subscribers in rural low income areas which have high concentrations of low income households and significant health disparities. This program will educate, inform, and triage patients who experience non-life threatening, non-urgent illnesses. It will connect patients with physicians licensed in each participating state to diagnose and treat mental health and addiction using easily accessible broadband technologies including cell phones, tablets, and computer devices.

The Center will maintain data to verify the impact that telehealth had on achieving the identified goals. Additionally, the template for the delivery of service will be capable of being replicated anywhere in the nation with the goal of insuring that every person has affordable access to high quality medical care when needed.

IV. Healthcare Conditions Effectively Treated through Telehealth

If selected to participate in the pilot, the Center will provide primary care services for patients in the service area. The Center will offer preventive care and public education about wellness and adherence to care plans. Information will be provided on immunizations, nutrition, and recommended routine testing to empower people to feel confident about managing their health. Additionally, the Center will address the opioid epidemic which has disproportionately impacted rural, poor communities. Psychiatrists will diagnose and treat patients who present with co-occurring problems with mental health and dependency. The Center will use technology to deliver behavioral health services, opioid and heroin addiction and recovery support, and Outpatient Based Medication Assisted Treatment (OBMAT). One of the most significant barriers to treatment involves the ability of addicts to adhere to care plans. Many addicts lack transportation. Some do not want the stigma associated with going to a treatment facility because they fear that their employers, spouses, or family members may react negatively putting jobs and relationships at risk. In many areas, patients must wait weeks for an appointment. Telemedicine will connect patients

to physicians quickly. The rapid response will have a meaningful impact on helping residents become free of drugs; for many, this will mean the difference between life and death.

V. Smart Goals

The Center applauds the FCC initiative and NOI for proposing to advance the benefits to mHealth virtual care to expand on the previous programs that focused on bricks and mortar. Because of our experience working with technology supported physician care, we are confident that we can address your goals of improving health outcomes through broadband access, increasing access to connected care everywhere, reducing health care costs, serving underserved and unserved areas, and increasing broadband among low-income households.

The Smart Goals program is designed to maximize funding and eliminate waste, fraud and abuse. The Smart Goals will directly benefit the subscriber in rural areas by providing real time access to quality healthcare.

What are Smart Goals: Measured and documented outcomes specific to resolution and costs per individual patient delivered through effectively and appropriately treating patients in remote settings utilizing telehealth technology.

How Smart Goals works:

1. Educates the broadband subscriber that mHealth is available and how to access care
2. Subscriber in need requests remote healthcare service through device to a "live" triage specialist
3. Triage specialist determines if request is appropriate and then connects subscriber via voice or video with healthcare specialist
4. Healthcare provider or physician develops supportive and caring relationship, consults, diagnoses and develops treatment plan (may include prescription if appropriate)
5. Entire event is securely documented and stored for continuity of care and resolution.

If selected to participate in the pilot, the Center will maintain data through HIPAA compliant protocols to support the impact of telemedicine in meeting health care needs. The Center will establish goals which are specific, measurable, actionable, reasonable, and timebound.

VI. Economic Model and Savings

The Center for the Advancement of mHealth is requesting pilot program funding for between 200,000 – 500,000 broadband subscribers located in rural areas which are considered unserved or underserved. Every effort will be made to focus on areas of low income concentration including locations with significant health disparities and escalating problems with opioid addiction. With effective education, 15% - 30% of a target population will access care through mHealth programs because telemedicine is convenient, accessible, and available. People are increasingly comfortable with their cell phones, computers, and tablets and they see access to medical care as just another way that technology can

improve their quality of life. For elderly patients or those unfamiliar with technology, education and support will be offered to encourage use.

The Center is proposing a 3year program at subsidized price per subscriber of $7.20 per year or $.60 a month.

- 200,000 subscribers at $7.20 a year = $1,440,000 annual for 3 years / $4,320,000
- 500,000 subscribers at $7.20 a year = $3,600,000 annual for 3 years / 10,800,000

The Center would be open to a larger pilot program of up to 1,000,000 subscribers and this would allow multiple geographic areas around rural and low-incomes areas of the US. The VHA remote patient monitoring program generated savings of $13,000 for every $1,600 spent; this equaled $8.00 in savings for every $1.00 spent.

Current mHealth data concludes the savings for each event will range from $250 - $450.
Using the baseline of 200,000 and 500,000 subscribers utilizing the service at a 15% and 20% annual rate, the following returns are projected:

- 200,000 subscriber program at 15% annual utilization will deliver $7,500,000 in annual savings – conservative outcome: $1 spent $5.20 saved
- 500,000 subscriber program at 20% annual utilization will deliver $25,000,000 in annual savings – conservative outcome $1 spent $6.90 saved

VII. Addressing the National Physician and Provider Shortage

The Center will use the pilot project funding to create a transformative policy to address the national physician and provider shortage. It is challenging for sparsely populated areas to support a thriving medical practice. Even when rural areas can support family practice physicians, there are often shortages of specialists. Some counties in the United States do not have adequate medical providers to meet behavioral health needs and addiction.

While there are not enough physicians to meet national needs, the distribution of care is not evenly distributed. Poor rural areas do not often have high tech hospitals and clinics to offer physicians looking to develop a practice. Housing, schools, and amenities in rural areas are less attractive than options available in more affluent and densely populated areas. Telemedicine will allow every patient to have appropriate medical access in any part of the country.

VIII. The Case for Telehealth

The United States currently ranks lower than other developed countries in overall life expectancy http://fortune.com/2018/02/09/us-life-expectancy-dropped-again/ while at the same time the nation outspends other countries in healthcare costs https://www.healthsystemtracker.org/chartcollection/health-spending-u-s-compare-countries/#item-start . There is clearly a breakdown between the quality of services provided and health care costs. Telehealth delivers care to millions of Americans that would

otherwise have no access. A telehealth physician can remotely see 5 -7 patients in the time it takes traditional clinics to see just 3.

Telehealth is critical to support an aging rural population. Many senior citizens are on fixed incomes and have limited insurance coverage. Telehealth helps older people to age in place by bringing providers to them to address chronic issues with the potential to become life threatening or life limiting. For example, a physician can provide telehealth delivered care to an older patient with diabetes to minimize the probability that the disease will progress to renal failure or amputations.

IX. Summary

For several years, The Center has reached out to the FCC to inquire about modifications or changes to the existing mHealth program. The Center has monitored the existing program and is appreciative to the FCC for their Notice of Inquiry in an effort to propose potential pilot programs that can directly impact the broadband subscriber.

Our consortium of Healthcare Providers and Physicians and wireless and wireline partners see significant benefits through providing this program with the cooperation of the FCC and funding available through the potential proposed FCC USAC mHealth pilot program.
This pilot program has the capacity to create a paradigm shift in the delivery of medical care in our nation. During the last two decades, technology changed every aspect of human life; it is appropriate for health care to fully utilize technology to improve health care access and cost.

X. Contact Information

For more information, please contact Marian Chambers at 1-724-984-8526 or Michael Iaquinta at 1-843-384-9617. Thank you for considering our comments.

Sincerely,

Michael P. Iaquinta
Center for the Advancement of mHealth